MEDICAL SERVICES AUTHORIZATION INVOICE

Michigan Department of Human Services

Case Name:
Case Number:
Date:
DHS Office:
Co: District: Section: Unit: Worker:
Specialist:
Phone:
Fax:
Specialist ID:

INVOICE NUMBER	Canceled-Void Invoice ☐

INSTRUCTIONS TO PROVIDER/VENDOR: Notify DHS at once if patient(s) fails to appear. **Missed appointments and unauthorized tests will not be covered. Retain a copy of this Invoice, with the Invoice Number for payment reconciliation.** Amounts billed must be the lower of either the DHS Fee Schedule Maximum or your usual, customary and reasonable charge for the service.

I certify the goods/services shown below were provided and that I did not and will not make any charge or accept any payment from the client or his family for the services provided on this authorization. I further certify that all services were rendered without regard to any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. Return signed Provider/Vendor Invoice with the DHS-93-A, or the signed DHS-93-A, with your report to the address above.

PROVIDER/VENDOR TO COMPLETE

a. FE ID No. Do not use Provider No.	b. Soc. Sec. No. Do not use Provider No.	c. MAIN Mail Code	d. Provider/Vendor Phone Number
e. Payee Name corresponding to FE ID No (if other than above)	f. Billing Address (if other than above)		
g. Patient Account Number or Birthdate	h. Specify Number of copies	i. Amount Billed	
j. Provider/Vendor Signature	k. Date		

SPECIALIST TO COMPLETE

Provider/Vendor Name	Provider/Vendor Number (not FE ID or SSN)		
Patient/Recipient Name	Individual ID Number	EDG #	Authorization Date
Description of Service Authorized	Program	Reason	

Specialist to complete upon return from Provider/Vendor

Specialist Approval - Requested Reports Received ☐ Yes	Date:

FEE SCHEDULE MAXIMUM

Exceeds Fee Schedule Maximum _____ Yes ☐ No ☐	Missed Appt Not Paid Yes ☐ No ☐
Specialist Signature Date	DHS Manager Signature (if needed) Date

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 280 of 1939, Federal CFR, and 45 CFR. **COMPLETION:** Mandatory.
PENALTY: Agency is unable to pay for medical services and materials.

DISTRIBUTION: Original to Provider/Vendor
Original to Local Fiscal Office after return from Provider/Vendor
Case Record Copy